OFFICE OF THE PRESIDENT OF THE REPUBLIC OF RWANDA
NATIONAL AIDS CONTROL COMMISSION

Rwandan Paediatric Conference on HIV and AIDS

REPORT

FIFTH ANNUAL NATIONAL PAEDIATRIC CONFERENCE

ON CHILDREN INFECTED AND AFFECTED BY HIV AND AIDS, 2009

Group of children from Arts University Center expressing the voice of children (Photo CNLS)

Children participants in their particular session (Photo cnls)

16-18 November, 2009 Kigali, Rwanda

ACRONYMS AND ABBREVIATIONS

AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retroviral Therapy
ARVs	Antiretroviral drugs
AZT	Zidovudine/Azidothymidine
CBC	Communication for Behavior Change
CDC	Center of Disease Control
CD4	Cluster Differentiation 4
DACC	District Aids Control Commission
DHS	Demographic and Health Survey
EGPAF	Elisabeth Glaser Pediatric AIDS Foundation
EID	Early Infant Diagnosis
FHI	Family Health International
FP	Family Planning
GF	Global Found
GLIA	Great Lakes Initiatives on AIDS
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HF	Health Facilities
HIV	Human Immunodeficiency Virus
ICFI	Infant and Child Feeding Index
IEC	Information, Education and Communication
KMH	Kanombe Military Hospital
MoH	Ministry of Health
MSM	Men who have sex with Men
NACC/CNLS	National Aids Control Commission
NGO	Non Governmental Organisation
NVP	Nevirapine
OI	Opportunist infection
OVC	Orphans and other Vulnerable Children
PBF	Performance Based Financing
PMTCT	Prevention of Mothers to Child Transmission
PNC	Pre-Natal Consultation
PwP	Prevention with Positive
STI	Sexually Transmitted Infections
SPH	School of Public Health
SRH	Sexual and Reproductive Health
TB	Tuberculosis
TDF	Tenofovir
TRACPlus	The Center for Treatment and Research on HIV/AIDS, Malaria Tuberculosis and other epidemic
UNAIDS	The Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

0. INTRODUCTION

The National AIDS Control Commission (CNLS), in collaboration with the Ministry of Health, the Ministry of Gender and Family Promotion and the United Nations in Rwanda organized, the 5th National Annual Paediatric Conference on Children infected and affected by HIV and AIDS from 16 to 18 November 2009.

This conference which focused on the theme, **"Count down to 2015 targets for children and HIV-Achieving Millennium Development Goal (MDG) 6",** brought together several persons including both national and international researchers, stakeholders in HIV area, clinicians and decision-makers at various levels as well as Ministers.

This conference serves as a platform to discuss priority issues based on field experiences. It was organized under 4 main areas, namely i) prevention of HIV among youth and adolescents, ii) prevention of mother-to-child HIV transmission, iii) paediatric care and treatment for children infected by HIV and iv) protection and support to orphans and other vulnerable children.

The conference unfolded as follows:

- Opening ceremonies with opening remarks;
- Technical sessions with oral presentations followed by discussions;
- Closing ceremony with presentation of conference recommendations, including the ones from children's sessions, prize giving and official closing remarks.

Conference objectives:

- Understand and review the existing coordination and implementation mechanisms of the national response towards achieving MDG 6 objectives for children and HIV;
- Explore and identify strategies and innovative approaches to address identified gaps around the **4 programmatic components of the national response for children and HIV;**
- Formulate recommendations on targets, key strategies and resources to be mobilized in order to achieve MDG 6 targets for children and HIV.

1. OPENING CEREMONY

Opening remarks

The opening remarks were delivered by Dr.Anita ASIIMWE, Executive Secretary of NACC (CNLS). Before presenting the theme of the conference, Dr. ASIIMWE first welcomed the participants and thanked the international « Key note speakers » who had accepted to come and attend the conference.

Dr. Anita Asiimwe E.S of the NACC welcoming participants at the opening ceremony (photo CNLS)

In exposing the theme, she pointed out that progress towards « MDG-6 » for PMTCT is remarkable and that we are on the right track to achieving universal access to HIV screening and ARV prophylaxis to women who are in need of it.
Indeed, 75% of pregnant women attending ANC are tested for HIV and access to ARV drugs for prevention of mother to child HIV transmission from infected mothers to their children has greatly increased over the last five years. In that particular area, Rwanda has gone over the transition towards more effective treatment regimen for PMTCT. Nearly 68% of HIV-positive women get ARV treatment for PMTCT and, even more importantly, close to 2/3 of pregnant women eligible to HAART have received it during pregnancy. But, there is still a long way to go to achieve universal access to early diagnosis of HIV.

Rwanda is undoubtedly on the right track to achieve universal access to treatment for HIV-infected children. Indeed, progress towards paediatric care and treatment is unprecedented. Increase in the number of children on HAART has been considerable. In not more than five years, the number of children treated with ARV has multiplied by 12. But we need to improve the overall quality of care for those who are receiving this treatment (including adolescents) and increase the aptitude to initiate early HAART for children infected through mother-to-child transmission.

We are probably on the right track to achieve « MDG-6 » for protection of OVC. But, we still need to identify all OVC requiring protection at the District level in the context of poverty and acquire a comprehensive package of basic services.

Based on available DHS data in 2005, nearly two-thirds of the youth are not sufficiently aware of HIV and have not used a condom in their latest high risk sexual intercourse.

Despite improvement in availing and allocating resources for HIV prevention, a lot of work still needs to be done in relation to defining and standardizing the comprehensive package in prevention of HIV in youth and, more importantly, we need to improve access to this intervention in implementation of those with "youth friendly" nature.

Speech by the Representative of the United Nations

Mrs. KARUSA KIRAGU who spoke on behalf of UNAIDS first welcomed the participants and gave them regards and wishes of the Executive Director of the UNAIDS, Mr. Michel SIDIBE on behalf of whom she congratulated Rwanda for great and commendable efforts made to achieve one of the highest PMTCT coverage rates (almost 70% in 2008) and for the good progress made toward achieving universal access. She said that efforts now being made here will help attain significant achievements in Africa. Rwanda is on the way to joining Botswana, Swaziland and Namibia in achieving universal access. She added that coverage rate in paediatric treatment is high (70%). She explained that behind each of these figures is a child with high hopes, a family with a better future, a proud and a coffin less nation. According to available data, Rwanda has probably the highest VCT coverage rate for couples in the world (73% of pregnant women are tested and counseled for HIV, 77% with partners compared with 5% all over the world in 2008).

She indicated that the 5th Conference is an important gathering since worldwide; 9 million children die of avoidable causes every year, including HIV, which represents 24,000 children per day. She welcomed the idea of including children in the conference and stressed that this is a way of putting them at the core of concerns and allow stakeholders to think about the next steps.

However, she went on to say that prevention should be intensified because it is difficult to implement and forces us into uncomfortable conversations on our sexuality, humanity, vulnerability, and their causes. She recalled that the global aim of 3X5, which was launched in 2003 to put 3 million eligible patients on ARV treatment by 2005, was not achieved until 2007. She drew the audience attention to the fact that for 2 persons treated there are five new infected individuals. She stressed that we need to remind ourselves that we will not treat our way out of the epidemic, and that prevention is for life.

She also insisted on the role of the family in HIV prevention and underscored the need for more support to families and communities, the need to identify different needs of children including those of marginalized groups as well as the need to provide integrated care to children.
Before closing her remarks, she once again congratulated the organizers of the conference and said that many countries had learnt a lot about Rwanda.

Mr. MUGABOWISHEMA Olivier, speaking on behalf of children.(Photo CNLS)

Group of children from Arts University Center expressing the voice of children (Photo CNLS)

1.3. Remarks by the representative of children

On behalf of all the children present at the conference, MUGABOWISHEMA Olivier said that it was a great pleasure for the children to attend the conference in order to see together what should be done to prevent HIV among the Rwandan people in general and among children in particular.

He recalled the four themes of previous conferences and declared that children were satisfied by what has been done. Achievements include anti-AIDS clubs in schools which have been offered support in terms of training and equipment; troupes which have been sensitized and supported with establishment of a forum for dialogue between children and their parents to talk about HIV, reproductive health and sexuality; radio programs produced by children in order to raise children's awareness on child rights, increase of VCT services in health centers, etc.
Concerning specific recommendations, he said that a cartoon and a pocketbook are being developed for all anti-AIDS clubs and villages.

However, some recommendations have not been translated into concrete actions. This is the case for the publication of a quarterly newsletter for children; multiplication of radio and TV programs on importance of voluntary testing; support to school institutions to help them improve their sanitation, nutrition and prevention of diseases like tuberculosis

and skin diseases; initiation of a counseling and psychological care program in schools, payment of school fees for needy children.

The Minister of Gender and Family Promotion delivering the official opening speech (Photo CNLS)

Official opening speech

The official opening speech was delivered by the Minister of Gender and Family Promotion, Mrs. MUJAWAMARIYA Jeanne d'Arc, who represented the Prime Minister. She said she was greatly honored to welcome all the participants to the 5th National Paediatric Conference of which theme was Monitoring of the progress made toward indicators corresponding to the Millennium Development Goals in relation to children and HIV.

She said that all participants were gathered for the conference because they shared the same belief that the situation of children can be improved. She said they all had the strong will to do whatever it takes to considerably reduce the number of infections in babies in order to promote an HIV-free generation.

In this context, she indicated that over the first six months of this year, a series of in-depth discussions took place with a view to developing a national strategic plan for the next 4 years in order to combine efforts and come up with a national response to HIV and AIDS.

She disclosed that debates and presentations of various studies and programs will give summarized statistics of the progress made and information on the perspectives for achieving the "MDG-6" and its indicators.

Going back to the messages given by children in their sketches and plays on sugar daddies and sugar mammies, she invited parents to take more care of their children's education particularly in relation to sexual education. She also urged them to educate themselves first and advised them to use condoms if they are unable to abstain from having sex.

Before declaring the conference officially open, the Minister expressed her heartfelt gratitude to UNICEF and other partners who had contributed to organizing the conference.

1.5. The Voice of Children

The Voice of children was expressed by a group of children from University Center for Arts through songs, dances and sketches in which messages on prevention of HIV in children and prevention methods like education, abstinence, faithfulness and correct use of condoms were conveyed.

The message that most attracted participants' attention was the phenomenon of cross generational sex in which « sugar daddies » and « sugar mammies » were exposed and condemned.
Another issue brought to light was the children's right to be tested for HIV and treated.

2. TECHNICAL SESSIONS

SESSION 1: SYMPOSIUM ON CROSS GENERATIONAL SEX AND PREVENTION CHALLENGES AMONG YOUTH AND ADOLESCENTS IN RWANDA

This session focused on the phenomenon of sugar daddies and sugar mammies that consists of sexual relations between children or young persons and adults.
After six months of a sensitization campaign called "SINIGURISHA " that was launched because, it had been proven that young people aged between 15-24 years have sexual intercourse with adults ten years older than them.

It was recalled that cross generational sex increases risks of HIV infection, STI, and unwanted pregnancies which lead to school dropouts, family conflicts and low productivity among the youth.

It was also recalled that SINIGURISHA sensitization campaign aimed at reducing cross generational sex (CGS) among adult men and women and young girls and young men aged between 14-20 years in order to prevent HIV transmission, STIs and unwanted pregnancies.

During the debates, everybody agreed that this phenomenon does exist and requested that every effort be made to stop it. Indeed, for students, CGS is a blight that must be curb at all levels. For the youth who dropped out of school, since this phenomenon is mainly due to search for material goods and money, there is need to be supported and encouraged to form cooperatives that could help them achieve financial autonomy. The parents' representative deplored the fact that it is only the children who sound an alarm while their parents seem to be indifferent to this phenomenon. He condemned all those who engage in these practices and advocated for improvement of the dialogue between parents and children on sexuality and appealed parents to take more care of their children's education. As for the representative of secondary school students, he invited his peers to content themselves with little things they get from their parents and pay attention when choosing their friends.

As the debate was drawing to a close, one of the participants addressing remarks to the children and young people, he said that the Rwandan society is changing and that they should therefore change with it. He invited children to learn to survive in a relentless world and use their knowledge. The participant advised them to wait for their time because "one can die of lack of food and drink, but one cannot die of lack of sex".

SESSION II: PREVENTION OF HIV AMONGST ADOLESCENTS AND YOUTH

Theme: «*Improving access to HIV prevention services for young people in Rwanda* ».

2.1. MDG-6 status for children and HIV in Rwanda: Rapid assessment

Dr. Anita ASIIMWE, E.S CNLS

The objectives of this presentation were the following:

1. Review progress towards achieving MDG-6 for children and HIV in Rwanda;
2. Identify gaps and challenges;
3. Formulate recommendations to inform the ways forward.

MDG 6 consists of « *Combating HIV/AIDS, Malaria and other diseases* ». It has two targets, namely: i) Halt by 2015 and begin to reverse the spread of HIV/AIDS; ii) Achieve, by 2010, universal access to HIV/AIDS treatment for all those who need it (Children and HIV related outcomes).
With regard to prevention, the outcome of the sub-objective will be (a) to reduce adolescents' vulnerability to HIV through information, skills and services. For protection, the outcome will be to increase the number of OVC receiving quality support (family, community and government).

The outcome of sub-objective (b) will be to reduce paediatric HIV infections (PMTCT) and increase the number of HIV infected children on HAART.

As a conclusion, it was indicated that by 2010,

- For prevention in youth: at least 95% of men and women will be fully aware of HIV and, for condom use, at least 95% of men and women who have high risk sexual relations use it;
- For protection: ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years reaches 1% of female and male;
- In PMTCT : the number of pregnant women attending ANC and tested for HIV reaches at least 80% ;
- The ratio of HIV+ pregnant women receiving ARV prophylaxis or ART for PMTCT is at least 80% ; at least 80% of infants born to HIV+ women receive a virological HIV test within two months of birth;
- Paediatric treatment: the percentage of children aged 0-14 years in need of ARV and who receive it reaches 100%.

Discussions and interaction

1. For proofs of interventions in favor of the youth, it was explained that Rwanda is on the right track but a data collection methodology is still missing. It was suggested to enhance the monitoring and evaluation system (EDS, survey reports, information sharing and dissemination of data).

2. As for babies born to HIV+ mothers, it was indicated that the target is 80% and that if efforts are maintained, there is no worry of missing the target. It is therefore important to sensitize service providers in babies' early diagnosis.

3. As for young people's easy access to health services, it was suggested to use adolescent friendly services to help young people use those services more easily.

A young girl attending the conference during debate and interaction session (Photo CNLS)

2.2. Improving access for youth and adolescents to friendly HIV prevention services In young people

Dr. Fatma Mrisho, Executive Chairman, Tanzania AIDS Commission (TACAIDS)

It was explained that the youth are being targeted because they are overrepresented in poor countries and unemployed. Despite their big number, they are neglected in national policies. Nobody voices their concerns and they are seldom involved in the development, implementation and supervision of programs.

Positive lessons learnt include the fact that information must be appropriate to age and sex, given in time and presented using multimedia approach. Parents, teachers and youth are important stakeholders with regard to HIV while interacting with the youth.

There is also need to develop life skills among the youth by building their confidence in taking reasonable and low risk decisions. It is also necessary to put at the disposal of the youth appropriate health services offered by competent people in a positive environment. It is therefore essential to establish a sound and supportive environment for the youth.

2.3. HIV prevention among youth towards achieving "MDG-6"
The Rwandan Situation

Sylvie NSANGA, Secretary General, RNYC

The prevalence of the age group of 15-19 is 0.5% (0.6% girls, 0.4% boys); for the age group of 20-24, prevalence is 1.6 % (2.5 % girls & 0.5 boys). The minimum age of the first sexual relation is 14 years for girls and 13 for boys. Only 51% of young girls of 15-24 years compared with 53.6% of boys have enough knowledge on HIV prevention with significant disparities (rural area: 48.1% and urban area: 63.3%).

The national response with regard to prevention in youth has been unequivocal. Indeed, strong mechanisms have been put in place by the Government to deliver qualitative HIV prevention services with the support of development partners. Comprehensive package in Youth Friendly Centers: life skills based education, VCT services and condom distribution, sexual reproductive health. Anti-AIDS clubs in schools & communities have been established and empowered, income generating activities for high risk groups, awareness campaigns (GBV, HIV/AIDS, family planning, and human rights, etc.).

Overall strategies in HIV prevention among youth are mobilization and sensitization; promotion of behavior change and distribution of condoms in youth associations, anti-AIDS clubs, universities and youth cooperatives.

Main challenges include financial constraints to help implement planned activities; weakness of coordination mechanisms, monitoring and evaluation of HIV prevention interventions among the youth and access of the youth and adolescents to friendly HIV prevention services which are still much limited.

2.4. An evaluation tool to measure the effectiveness of youth peer-education training
Emmanuel RUCYAHANA, Youth Services Manager, PSI/Rwanda

In 2009, PSI Rwanda supported youth friendly centers "Dushishoze" in Huye, Musanze, Ngoma, Gasabo, Nyarugenge and Kicukiro Districts. A fully integrated sexual and reproductive health (SRH) service package is offered at youth centers, including VCT, FP service delivery, referrals to health facilities for follow-up clinical services, special events, IEC materials, and peer educator (PE) training and outreach etc.

With regard to methodology, 600 youth on total were trained. 85% of peer-educators (509 out of 600) completed the questionnaire before and after training and were included in the analysis. The findings have been compared for each series of 16 questions and for 5 questions on full knowledge of HIV. Crossed presentations have been made per gender and per district. The chi square test has been used to assess various results before and after the training. The meaning threshold being $p<0.05$.

According to findings, peer-education training has improved skills in general knowledge and also in HIV but 1 youth in 3 were not yet fully aware of HIV after the training.

Training increased knowledge in reproductive health especially when it comes to knowing when and how a young girl may get pregnant.

The study recommends the use socio-economic data collection tools (e.g. rural or urban residence, education) with the questionnaire in order to better understand factors that impact on knowledge. It also recommends harmonizing youth training and evaluation tools. As for services, the study recommends improving youth's access to recent data on family planning and comprehensive reproductive health services.

2.5. Cross Generational Sex Campaign (CGS) "SINIGURISHA"

Jean Pierre AYINGOMA, CNLS

The cross generational sex campaign was conceived and designed by NACC with technical support from PSI/Rwanda. It was launched by the Ministry of Youth in May 2009. Implementation task force consisted of MINIYOUTH, NACC/CNLS, UNICEF, UNFPA, and PSI.

With regard to CGS, it was recalled that it consists of exchange of gifts and money in return for sex, between older men/younger girls, and older women/younger boys. CGS increases the risk of HIV, sexually transmitted diseases, unwanted pregnancies.

The campaign aimed at reducing CGS between older men/women and young boys/girls aged 13-20 to prevent HIV transmission.

The slogan for the campaign was « SINIGURISHA » (I do not sell myself) and the messages conveyed read as follows: right to say no to CGS; ability to resist peer pressure to engage in CGS and self-worth. Crosscutting message was "Sugar Daddies/Sugar Mommies are 'Enemies of Rwanda's Bright Future".

2.6. Determinants of HIV status among youth aged 15-24 accessing VCT services at "*Dushishoze*" youth centers in Rwanda

RUTON Hinda, TRACPlus

The objective of the study was to measure the level of HIV positivity among male and female youth aged 15-24 who were tested for HIV at *Dushishoze* centers and determine which factor are associated with being HIV positive.

32,355 youth aged 15-24 were tested at *Dushishoze* centers with non-indeterminate HIV result in 2007 and 2008. 90.8% were not married. Median age of the first sexual intercourse was 18 (CI=16-20). 56.1% (18,033/32,146) were sexually experienced. The overall HIV positivity among all youth accessing VCT services was 2.8% (3.3% female, 2.5% male). Females were more likely than males to be HIV+ and older youth of both sexes were more likely than younger youth to be infected ($p<.05$ for all comparisons).

As a way of conclusion, it was indicated that *Dushishoze* centers successfully reached youth who were almost 3 times more at risk of being HIV positive than the national

average. Among youth who sought VCT at Dushishoze centers, females – especially those aged 20-24 – were most at risk for HIV. Risk factors for HIV infection among youth aged 15-24 attending these youth-friendly VCT services may differ substantially from the adult population.

The presenter recommended that Programs should continue to develop and strengthen evidence-based HIV prevention interventions targeting high-risk youth, and encourage access to care and treatment for HIV-infected youth, particularly among female youth. There is also need to develop screening tools and evidence-based prevention interventions for youth with a history of sexual abuse and concurrent sexual partnerships. Finally, there is also need to promote correct and consistent condom use among youth.

Discussions and interaction

1. Concerning identification of youth groups on which to focus more attention, it was indicated that high risk youth are found at the borders of Kenya, Zambia, DR Congo and Malawi. Other high risk youth are found in universities;
2. For the phenomenon of unwanted pregnancies on schools, it was explained that this issue is being closely monitored in MINEDUC by a coordination unit. In this connection, it was suggested to teach family planning methods to nurses in schools in order to help young students;
3. As for identification of sugar daddies and sugar mammies, it was indicated that it is a very difficult exercise. However, it was announced that a process in progress to oversee motels, and hotels in collaboration with the national police. In Tanzania, the phenomenon of sugar daddies is more widespread;
4. Factors leading to CGS include economic factors which prompt youth to adopt materialism and lack of education which prompts youth to be willing to live above their families' means;
5. As for peer-education limitations, it was explained that there are school drop-outs in the group of trained youth and that the training is organized for youth from cooperatives. Monitoring is carried out through DUSHISHOZE centers;
6. For youth living in refugee camps, GLIA and UNFPA are taking care of that vulnerable group.
7. With regard to impact of campaigns like SINIGURISHA, it was explained that such an impact may not be visible before 3 to 5 years. SINIGURISHA evaluation survey will be conducted next year.

SESSION 3: PROTECTION AND CARE FOR ORPHANS AND VULNERABLE CHILDREN

Topic « *Strengthening family's ability to ensure protection, treatment and care for OVC*».

3.1. The potential of cash transfers to strengthen families affected by HIV and AIDS

Chris Desmond, International key note speaker
FXB Center for Health and Human Rights, HSPH.

Chris Desmond, making his presentation (photo CNLS)

Cash transfer contributes to strengthening financial resources and is a necessary aspect of strengthening families. It is one approach to strengthening family financial resources. Cash transfer is a response to poverty.

Cash transfer has an impact on the life of families because it helps resolving problems and is an effective means to financially strengthen families. Cash transfer is indeed some kind of social protection. It is also a form of justice, not charity.

He finally recalled that families have the potential and that cash is one way of helping them realize it to the benefit of their children and our future.

3.2. Vision 2020 Umurenge Programme (VUP),

Justine GATSINZI, VUP Coordinator

VUP is an integrated social protection program - a flagship of the Economic Development and Poverty Reduction Strategy (EDPRS) 2008–2012.

The purpose is to reduce extreme income poverty and bring improvements in other human poverty dimensions such as education, health and nutrition.

- Direct beneficiaries are extremely poor households in operational areas. They are targeted through a community poverty mapping process (Ubudehe) plus additional land and labor criteria.

All children from poor families are eligible to the program through improved access to micro-finance institutions, loan and training as well as increased household awareness and skills on e.g. health, hygiene, family planning, nutrition etc. through training and sensitization activities. By increasing income, this program has a really positive impact. This helps break the cycle of poverty. Thus, beneficiary families have obtained health insurance, improvement of the quality and quantity of food, children's education through payment of school fees and materials.

Discussion and interaction

1. Concerning factors which cause HIV infection in OVC, children blamed delay in provision of school materials, the fact of putting boys and girls in the same houses as well as lack of parent's strictness;
2. With regard to the use of VUP money, it was explained that it is spent following the conditions defined by beneficiaries. Then, monitoring and evaluation come only later;
3. As for the aids which reach beneficiaries, it was explained that it can be the result of faulty targeting;
4. For poverty alleviation purposes, it was indicated that strategies are worked out based on conductive factors. Then beneficiaries are perfectly targeted in order to effectively point to the right targets.

3.3. Integrating HIV prevention and care with treatment of Psychological trauma in vulnerable Rwandan youth: A Community-based Intervention

Chaste UWIHOREYE, UYISENGA N'IMANZI

WHO studies reveal that people with psychological problems are ± 30% to 60% at risk of being infected by HIV/AIDS. Research carried out by MOH indicated that 28.54% of the general population of Rwanda lives with psychological trauma.
Whereas at Ndera Neuro-psychiatric Hospital, out of 524 people tested, 34 were HIV+ and 3 of them were Children. This situation is due to the fact that people living with psychological trauma are exposed to multiple partners, sexual violence and unprotected sexual intercourse.

The impact of this situation is lack of capacity to use HIV/AIDS related information and lack of capacity to adopt the protected behaviors. Rwandan vulnerable youth suffer from lack of foster families, friends or adult supervision; they are sexually active, burdened by psychological trauma, as well as increased risk for HIV infection and transmission.

HIV is linked with various consequences (social, psychological, physical, economic, legal, community, relational and family) and prevention solutions should also be complex. Community-based psychological intervention is one among the solutions.

3.4. Mental Health and Resilience in Children Affected by HIV and AIDS in Rwinkwavu, Rwanda

Félix Rwabukwisi Cyamatare

By 2007, an estimated 220,000 children had lost one or both parents to AIDS – representing 43% of all orphans in the country (WHO/UNAIDS/UNICEF, 2008. Consequently, the Ministry of Health and Partners in Health prioritized development of mental health services.

For that purpose, evidence-based interventions were originally developed for children of depressed caregivers. Besides, interventions should be designed to be administered by a range of providers. A family-based preventative model would focus on identifying and enhancing resilience and communication in families.

Intervention objective is to bolster protective processes including connection, social support and communication, increasing children's resources to achieve resilient outcomes.

There is need to develop strengths-focused intervention for children and families facing many forms of adversity.

3.5. Depression among Youth Heads of Household in Mentorship program Bugesera District, Rwanda

MUKABUTERA Assumpta, MPH candidate

In Rwanda there is large number of child-headed households. More than 65,000 households are living without adult care and supervision. As a solution, World vision Rwanda (WVR) in partnership with Rwanda School of Public Health and Tulane University initiated an adult mentorship program in 2004. This mentorship program is a community-based approach that consists of home visit program and utilizes trained and volunteer adults to provide psychosocial support to Youth Heads of Household (YHH).

The objective of the study is to assess the psychosocial characteristics of youth in mentorship program and report on depression outcome in youth participating in the mentorship program in BUGESERA District.

The study found that out of 201 YHH, 55% were females and 45% were males. Their average age varies from 11 to 24 years and about 54% of them achieved primary school, 26% completed 6 years of primary basic education and 8% reached secondary school. One out of four lives alone in the household.

The conclusion is that interventions that provide psychosocial support to children should be scaled up and provision of food and increasing household assets should be integrated into psychosocial interventions. Finally, there is need for further studies to analyze the reason why older children demonstrate more depressive symptoms.

Discussions and Interactions

Discussions about this session focused on the following points:

1. Depression was evaluated by a validated scale with 32 items;
2. As for factors that contributed to reducing unwanted pregnancies among vulnerable children, it was said that they included solidarity camps, school reintegration, psychological support, formation of cooperatives and reference adults in the community;
3. With regard to the link between Vision 2020 Umurenge Program and OVC protection program of MIGEPROF, it was explained that among VUP beneficiaries there are children. Both programs are complementary and aim at improving the wellbeing of OVC. However, VUP interventions are more sustainable;
4. Concerning cash transfer, the presenter indicated that economic impact is important because the money is spent locally. However, there are risks that in case large sums of money were distributed; the beneficiary could do all it takes to remain vulnerable.

SESSION 4: SYMPOSIUM ON UNIVERSAL ACCESS TO HIV PREVENTION, CARE AND TREATMENT SERVICES IN THE HEALTH CARE SECTOR.

4.1. Toward universal access: intensification of HIV/AIDS priority interventions in the health care sector.

Dr. François SOBELA, OMS

Universal access has been defined as a broad concept with the following 3 dimensions of the main interventions in the health care sector:
- **Availability**: reachability, affordable and acceptable;
- **Coverage**: defined as the proportion of the population needing an intervention who receive it;
- **Impact**: defined as the reduced new infection rates or as improvement in survival. Impact objectives have been set in the context of the Millennium Development Goals.

It was recalled that the HIV pandemic remains a big challenge for global health with some 33 million PLWHIV and 2.7 million new infections in 2007. However, in 2006, countries resolved to work toward achieving the objective of universal access to HIB prevention, treatment, and care (high level meetings on AIDS).

As for HIV Counseling and testing, 90 % of countries have developed national HIV control policies, and it is free of charge in 94 countries. VCT services have increased from 25.000 in 2007 to 33,600 in 2008 (35%). However, knowledge of HIV status remains low: less than 40% of PLWHIV, less than 40% among women and less than 30% of men know their HIV status.
Concerned with HIV prevention are high risk persons like drug addicts, MSM, sex workers and prisoners. HIV prevention also deals with STI management, male

circumcision, safe blood transfusion, post exposure prophylaxis as well as prevention and care for PLWHIV.

Out of 9,500,000 of ARVs, the total number of persons receiving this treatment has increased from 2,970,000 in 2007 to 4,030,000 in 2008 in countries with low to medium income among children and adults put together. Children receiving ARV treatment amount to 275,000 against 3,755,000 adults.

As for intensification of HIV services for children and women, the presenter pointed out the national political commitments to expand HIV prevention, treatment and care services which have been intensified over the last few years. In 2008, 70 countries drew up national PMTCT intensification plans against 34 in 2005. Similarly, 54 countries had national plans for intensification of HIV paediatric services in 2008 compared with 19 in 2005. The percentage of HIV+ pregnant women receiving ARV treatment has increased from 35% in 2007 to 45% in 2008. At the same time, coverage of antiretroviral prophylaxis among children has increased and reached 32% in 2008 against 20% in 2007. The number of HF offering antiretroviral therapy has increased to approximately 80% from 2007 to 2008.

Despite considerable progress, the comprehensive response to HIV remains a real challenge. Priority areas for countries and their partners include:

- Expansion of HIV counseling and testing and prevention services;
- Paying more attention to high infection risk populations;
- Ensuring access to treatment in time;
- Increasing retention and adherence to treatment as well as quality services provided;

Dr. François SOBELA from WHO presenting during the Symposium on universal access (Photo CNLS)

4.2. Rwanda achievements and challenges toward universal access to HIV prevention, care and treatment services in the health care sector

MUGABO Jules M.D., HIV, AIDS and STI Unit, TRACPlus/ Rwanda MOH

For Rwanda, universal access to HIV prevention, care and treatment services means 100% access to the services by those in need at a point in time without any geographic, gender, age-based, vulnerability barriers.

As for prevention program, there is HIV testing (VCT, PMTCT and PIT) For the following target groups: pregnant women and their partners under PMTCT, exposed children, couples and children in VCT, street children, sex workers and their clients, truck drivers and soldiers. Prevention is also done through IEC/BCC, condom use, male circumcision, post exposure prophylaxis and HIV prevention in discordant couples.

The HIV care and treatment program consists of OI prophylaxis (CTX, Dapsone, fluconazole); screening, diagnosis and management of STI, OI (TB, Cryptococcal meningitis and side effects; Provision of ART; Patients monitoring and follow up, psychosocial and adherence support; nutrition program, family planning; positive prevention; PBF as well as community based intervention (HBM, IGA, OVC, Mutuelles, etc). Until the end of September 2009, there were 73,769 persons among whom 67,491 adults and 6,278 children under ARVs. 72,501 persons were receiving the first line regimen whereas 1,268 received the second line.

Perspectives include:

- Increasing VCT/PMTCT/ART geographic coverage;
- Reinforcing HIV prevention in post partum period;
- Defining and scaling up comprehensive packages for HIV prevention services in high risk populations;
- National Plan for HIVDR;
- Improving diagnosis and treatment of OI;
- Strengthening capacities of lab facilities;
- Increased community participation;
- Staff training and retention with emphasis on task shifting.

Discussion and interaction

1. Concerning re-screening of pregnant women in order to prevent mother-to-child HIV transmission, it was explained that where the mother is HIV- and the father HIV+, it was said that there was no policy in Rwanda for new testing. But the woman receives the same treatment as an HIV+ woman. Nonetheless, an appropriate strategy is being developed;
2. As for early diagnosis of children, it was indicated that the policy is quite clear. At present, an ad hoc committee is working on it in order to come up with a way forward. However, there are still challenges relating to traceability of women and children, confidentiality and adequate transportation of samples. At this point, it

was also mentioned that it is the right of the child to be tested and the right of parents to decide. Unfortunately, the guidelines give more power to parents. As for lab facilities, there are plans to install a laboratory per Province;

3. Concerning sex workers, there is need for an overall approach mainstreaming all the parameters to be taken into account because this is a very mobile group;
4. With regard to improvement of quality insurance, it was recalled that Rwanda has made considerable progress but contribution of the health sector needs to be optimized and continuity of HIV treatment ensured. However, Rwanda should put in place appropriate strategies to increase the number of persons knowing their HIV status and the rate of condom use by considering aspects relating to culture and religion. Concerning quality in particular, it was underscored that it is important to put in place an integrated tool for audit, training sessions and supervision;
5. As for opportunities to achieve universal access in Rwanda, evaluation should be carried out to assess needs of health centers. This evaluation exercise will help the Rwandan government allocate funds appropriately. Policies also need to be reviewed to ensure better management of the personnel. Communication must also be used for development in order to better address issues relating to culture and stigmatization. Finally, there is need to put in place an evidence base by strengthening for instance monitoring of recommendations made by various conferences;
6. Concerning pregnant women, it was suggested to provide them with ARV treatment as a matter of priority;
7. For partnership and coordination aimed at giving greater importance to prevention, it was advised to rely on multidisciplinarity and take into account of socio-economic foundations;
8. As for opportunities in financing accessibility of HIV services, a range of projects were mentioned including good geographic coverage, construction of new health facilities, good mainstreaming policy, common supply basket, generalization of the diagnosis as well as universal access. Current challenges include the use of outdated drugs and many children now under treatment who will shortly become adults.

SESSION 5: PREVENTION OF MOTHER-TO-CHILD HIV TRANSMISSION (PMTCT)

Topic: *"PMTCT quality services for all: towards an HIV-free generation"*

5.1. Elimination of HIV among children by 2015: A reality or rhetoric!

Dr Dorothy Mbori-Ngacha, MD, Mmed, MPH
PMTCT & Paediatric HIV Advisor, UNICEF ESARO

The keynote speaker said that she was evoking the declarations in the context of universal access, from 2010 to 2015 that require universal access to HIV/AIDS prevention, care and treatment for those in need of them and eradication of HIV infection among infants and children (Abuja - Call to Action).

One way to achieve eradication of HIV among infants is safe breastfeeding. The effects of ARVs given during pregnancy are alleviated by breastfeeding. We must maximize profits and minimize nuisance.

The ARV prophylactic regimen among suckling infants are effective in reducing postnatal infection in all maternal CD4 counts strata. However, even with infant prophylaxis, the rate of postnatal infection among children born from mothers with less than 350 CD4 was significant. Introducing HAART for women with less than 350 CD4 would be beneficial to maternal health and reduce HIV infection among infants. Therefore, for infant feeding, people should encourage exclusive breastfeeding until 6 months, discourage stopping of breastfeeding before 6 months and introduce complementary feeding at 6 months with cessation of breastfeeding when adequate nutrition without milk is ensured.

Regarding PMTCT, Rwanda is seen as a model in Africa but there is need to integrate PMTCT into all health areas. We must therefore strengthen laboratory capacity, reinforce monitoring and evaluation as well as development and implementation of locally simplified versions adapted to guidelines and tools.

5.2. Overview of the national PMTCT Programme

MUGWANEZA Placidie, MD
Prevention Department/TRACPlus

In Rwanda, the fertility rate is 5.5 children per woman, and ANC visits (antenatal consultations) are 96%. While deliveries in HF represent 64.5%, immunization coverage reaches 80% fully immunized and 90% for measles alone.

Concerning the intensification of the national program:

1999-2000: pilot centre at Kicukiro Health Centre;
2001: Definition of PMTCT goals by TRAC*Plus*;
2002-2005: Beginning of Sd NVP at decentralized level;

End 2005: initiation of more efficacious ARV regime in PMTCT;
2006-2009: National Expansion of PMTCT services including EID.

As a result, the number of health facilities offering PMTCT services has increased, 75% of pregnant HIV positive women and 63.3% of HIV negative women gave birth in the HF, while 88% of exposed children were fed using exclusive breastfeeding.

Among factors of PMTCT success, we can report good policies and coordination such as, for instance, the involvement of Government, community-based health insurance systems, PBF, mobilization and community involvement. There is also shifting to more effective ARVs regimen required like the decentralization of ARV counting system, reorganization of services and the transfer of tasks.

However, the program faces challenges such as the national coverage of PMTCT, newborns infected despite the PMTCT program (6.9% in 2008), increasing ARV regimes more effective and the weaning food for children exposed to HIV.

To cope with these challenges, the following are required:

- Funds mobilisation for PMTCT expansion;
- Linkage between HF and community;
- Adapt national PMTCT guideline to WHO 2009 revised guideline;
- Integration/reinforcement of prevention with positive program (PwP) activities in PMTCT services;
- Implementation of task shifting policy;
- Strengthening psychosocial support and adherence to programs;
- Weaning food initiative.

Discussion and interaction

1. Regarding protected food for children at risk, it was stated that so far there is no policy; yet it is a prospect;
2. Regarding the establishment of new sites offering ARV services, it was said it goes hand in hand with training of services providers;
3. Regarding early treatment of children, it was clarified that it is important because it leads to better results. Indeed, the earlier children begin treatment, the faster they heal;
4. Regarding the breastfeeding of children at risk, it was recalled to recommend exclusive breastfeeding for the first six months because stopping breastfeeding at 6 months reduces infection risks;
5. Concerning stigmatization, it was stated that the only way to end stigma is to break the silence about HIV;
7. With regard to mother or infant prophylaxis, it was explained that people should make a choice but studies have shown that in cases where infants received nevirapine, there was very little toxicity. The advantage of focusing on the baby is

that it offers an opportunity to monitor the child and connect it with other services such as immunization;

8. Regarding the integration of PMTCT in reproductive health services, it was said that this integration takes place throughout the program implementation.

5.3. Closer monitoring of children exposed to HIV through immunization services.

Nadine UMUTONI WA SHEMA, TRACPlus

Monitoring children exposed to HIV to determine their HIV status is a major challenge for the PMTCT program in Rwanda. The assessment of tracing overlooked people living with HIV conducted by TRAC*Plus* team with its partners from January 2007 to December 2008 showed that there are 32,989 over 112,977 overlooked in HIV programs and 3095 over 15,410 Children overlooked. 14.1% of these children have not been tested for HIV (PCR serology), 7.9% did not receive ARV prophylaxis at birth and 6% did not receive CTX prophylaxis for 6 weeks.

As a solution, it was proposed to extend the immunization program, which is very satisfactory and can reach up to 90% of children at 9 months with the measles vaccine and the integration of monitoring of children exposed to HIV in routine immunization services.

Although monitoring of infants exposed to HIV is not fully integrated into immunization services, service providers believe it is feasible to provide integrated monitoring of infants in immunization services the same day if the vaccination staff is adequately trained in PMTCT and has an easy way to identify children exposed to HIV.

Nevertheless, the level of integration of monitoring infants exposed to HIV in immunization services remains poorly coordinated at HF level. A standardized system of HIV integration in immunization extension programs is required to optimize monitoring of children exposed to HIV in national PMTCT program.

5.4. Assessment of feeding practices using a summary index and a nutritional status among HIV-exposed infants in Rwanda

Joséphine Kayumba, TRACPlus

In Rwanda, the GDP per capita is 250 USD, this is absolute poverty. The population density is very high, and HIV prevalence is 3%. The estimated rate of HIV transmission from mother to child is 6.8%. Breastfeeding rate is high (97%) with an average duration of 25.5 months and a low rate of timely introduction of supplementary feeding (31%).

The response of Rwanda with regard to nutrition has been to improve the guidelines of a food index for infants and children, an accelerated program of supplementing vitamin A and immunization as well as the integration of nutrition activities related to PMTCT.

In conclusion, we have noticed a small increase of ICFI as components of milk coupled with acute malnutrition, underweight as well as other components which improved with age. The nutritional status is stronger among infants over 12 months and a high proportion of severe form. The ICFI and the nutritional status are associated with acute malnutrition and underweight. We have seen that gender was associated with all anthropometric results even after controlling other covariates.

Recommendations:

- develop monitoring and evaluation tools;
- importance of milk in breastfeeding practices and taking advantage of availability of ARVs among HIV positive mothers and overall rate of breastfeeding in Rwanda;
- consolidate and strengthen nutrition programs;
- conduct in-depth analysis of the relationship between gender, feeding practices and the nutritional status.

HIV prevalence among women attending antenatal care services (ANC) at Kanombe Military Hospital, 2006-2008

C. Muhinda, Kanombe Military Hospital

HIV prevalence among pregnant women is 12% in Kigali, compared with 4.3% nationally. Moreover, the trend is that the prevalence keeps increasing among women aged 15-19.

The response of Rwanda in this situation was the implementation of Antenatal care (ANC)-based sentinel surveillance (SS) since 1989, increased services of VCT, PMTCT, care and treatment Since 2004, scale-up of HIV counseling and testing, prevention, including prevention of mother to child HIV transmission (PMTCT), care & treatment services.

The aim of the study is to determine HIV prevalence trends among pregnant women in the catchment area of Kanombe Military Hospital (KMH) during 2006-2008, to describe the population of HIV-infected pregnant women according to person, place, and time as

well as provide a basis for further public health action. The study found that Gasabo District has the highest prevalence (12%) while Kicukiro has the lowest (10%).

The study showed that HIV prevalence among pregnant women attending KMH increases gradually during this period and is higher among pregnant women aged 25 to 29 years and lower among those aged 15-19 years. However, the trend of prevalence may change on basis of 2007 data.

Therefore, the study recommends strengthening HIV prevention efforts for women aged 25-29 years in Gasabo and Kicukiro Districts. Also, access and use of PMTCT services should be promoted.

Discussion and interaction

1. Regarding the difference in malnutrition between boys and girls, there was no convincing explanation of this phenomenon;
2. Regarding the immunization card that integrates the monitoring of exposed children, it was indicated that health workers are able to treat and keep confidential information. It was also recalled that counseling remains the basis for success. Regarding stigma, it was said there is no reason to worry but decision will be taken during evaluation. We should also know that the card helps identify children at risk. Another advantage is that it will decrease the number of mothers' visits to HF.
3. Concerning the discrepancy observed between findings of the study on prevalence among pregnant women attending Kanombe Military Hospital and national prevalence, it was explained that this trend may be the result of fewer women who followed this program at this time. Participants wanted, for more clarification, a socio-demographic study to be conducted to identify the provenance of these women and their category.
4. On the issue of breastfeeding after six months for HIV positive women, it was indeed recalled that breastfeeding at this time carries risks of infection but people must understand that after six months, if there is no food supplement, the child may die of malnutrition.

SESSION 6: PEDIATRIC CARE AND TREATMENT OF HIV INFECTED CHILDREN

TOPIC: ***"Early Diagnosis of HIV for early treatment of children"***

6.1. From "PMTCT" to maternal and infant care of HIV
Douglas Watson, M.D., University of Maryland School of Medicine
International keynote speaker

The risks of HIV mother-to-child transmission are as follows:
- 1st term: less than 1%;
- 2nd term: less than 2%;
- 3rd term: 5%;
- At birth: 13%;
- After 24 months of lactation/breastfeeding: 15%.

Cumulative risk at birth is 20% while the cumulative rate is 35%.

Regarding the integration of antenatal and postnatal HIV care for children, we must proceed with pre and post test counseling including risks and interventions. We must also obtain the CD4 count according to the state of a patient, his/her preparation for adherence, prescription of antiretroviral drugs and cotrimoxazole, community-based support, diagnosis of infants (PCR and RT) several times, rapid introduction of ARVs for infected children, retention of the mother to HIV care and measuring outcomes.

In conclusion, the study indicates that limiting breastfeeding may be dangerous. We should at least monitor mortality. We have means to prevent most HIV transmission from infected mother to her child. Also, many technical problems have to be solved. With regard to infant nutrition, advice must reflect individual circumstances and be based on evidence. It goes without saying that active management of both the child and its mother must be done throughout pregnancy, childbirth and through the first two years of life by clinicians trained and experienced in maternal and infant care against HIV.

6.2. National program for Pediatric HIV /AIDS Care and Treatment
Sabin Nsanzimana, M.D, HIV, AIDS and STI Unit TRAC Plus/MOH

The ideal diet in public health should be simple and measured properly, sustainable and effective, that is to say, with low dose-limiting toxicity and predictable degree of viral suppression. It should also, among other things, have a predictable pattern of resistance and be financially affordable.

Patients' monitoring is done through medical and laboratory monitoring by CD4 count and measure of viral load. Regarding achievements, we can point out the training of trainers, increase in the number of children treated with ARVs, updating of national guidelines, the evaluation study of pediatric ARVs currently used and an assessment of

care for teenagers. The fact is that the standards and procedures for care and treatment have been developed, the establishment of a pediatric centre of excellence at CHUK and psychological support groups (counseling) including the information for children.

In perspective, we especially intend to strengthen the scrutiny of tuberculosis, cryptococcal meningitis of STIs, cervical cancer, side effects, planning and prevention with the positive/infected women. In addition, we will continue to decentralize and integrate HIV services, set up mentorship teams at all levels, continuously build capacity at all levels, create centres of excellence and strengthen community involvement in care.

Among the challenges faced by the program: early diagnosis of children at risk, laboratory equipment to diagnose OIs, STIs, adherence to ARVs, recognition of treatment failure by resistance testing, the availability of ARV drugs for children multi-experienced to ARVs of the 3rd line and lack of long-term capacity building.

6.3. Health and prevention services for teenagers

Dr Agnes Binagwaho, P.S MOH

According to WHO, teenagers are divided into three groups namely:

- Young teens: 10-14 years;
- Older teens: 15-19;
- Young adults: 20-24 years.

These teenagers represent one-third of the national population. There are persistent gaps for these teenagers to access health services especially in the fight against HIV/AIDS, prevention of HIV and STIs, care and treatment as well as a comprehensive strategy.

The objective of this study is to offer an overview for policy makers.

The study showed the existence of many challenges including gaps between knowledge and the capacity to implement, lack of infrastructure, trained personnel and friendly guidance not to mention social pressures.

The study recommends training on how to apply knowledge, access to high-quality health and HIV services, social support and change of standards and establishment of a national policy on teenagers' health.

Discussion and interaction

1. Regarding the regimen for children aged less than 18 years, it was reported that the treatment had been proposed even before because it was shown that the sooner the treatment begins, the more there is adherence. Ethically, we must treat children early.
2. Regarding the youth who use drugs, it was said that this is a crucial problem because service providers are not trained adequately to deal with it. As for supporting them, there exists a protocol relating thereto.
3. Regarding the parent-child dialogue, it was recalled that CNLS in collaboration with the First Lady organized a campaign on the matter. The remark is that there are more and more taboos but sensitization work must continue because children can be a catalyst of the change.
4. Regarding the youth education, it was recognized that young people are easy to educate but the guides/manuals/books must be reviewed and that service providers are trained. In addition, participants advocated that young people have the right to decide testing by themselves without necessarily going through parents.
5. Participants also requested to review the manual on PMTCT to include nutrition.

Some of the conference participants following their Oral presentation (Photo CNLS)

6.4. Adherence of teenagers to HIV care and treatment: Experience of CHUK and CHUB

Pr. Narcisse MUGANGA, CHUK

Risk factors for poor adherence in adolescents are:

1) Feeling of invulnerability, denial and a strong desire for independence;
2) Alcohol and drug abuse;
3) Unprotected sex or failure to submit to monitoring and treatment.

The methodology followed is that ARV initiation must be done according to national guidelines; there should be monthly medical visits and a CD4 count twice a year. Announcement and engagement should also be done at an appropriate age to educate about HIV infection, adherence to treatment, secondary prevention and positive living and to provide support as required.

To measure adherence, we reviewed the registered appointments and counted the tablets remaining in the pharmacy during the treatment.

Teenagers at CHUK and CHUB showed good adherence to treatment and care. However, adherence of those living with care takers other than parents and older teenagers could have with difficulty.

6.5. Early ART Initiation Leads to Excellent Survival in HIV-Infected Infants in Rwanda

RUHAYISHA B. Robert, MD, Kirehe Hospital

There are overall 2.3 million children infected with HIV. There is also early access to pediatric care and treatment of HIV but mortality remains high in infants often before the diagnosis and CD4 count.

WHO 2008 revised guidelines for ART initiation in children state that we must initiate ART for all, regardless of CD4 cell count or clinical stage. Initiation of ART by clinical or immune criteria (CD4 cell count and percentage based on age). According to the recommendations of the Rwandan Ministry of Health (MOH), all babies infected with HIV aged under 18 months should be introduced to ARVs. "Partners In Health (PIH)" in partnership with MOH have initiated in Rwinkwavu and Kirehe District comprehensive pediatric programs of HIV and PMTCT and 582 children infected with HIV were followed up while more than 2,500 HIV-exposed children have received care.

PCR results were obtained for children of average age of 3.3 months with a range of 2 to 9 months. 15 children (20%) were found infected with HIV. One HIV infected child died at the age of 4 months before being introduced to ARVs. All the remaining 14 children started ARVs and 100% of those who started have survived until now. The average age of initiation of ARVs was 7.1 months with a range of 3 to 13 months. These results support the implementation of guidelines on the early initiation of ARVs to children because it allows excellent survival of children infected with HIV who started ARVs before the age of one year.

For this reason, there is need for additional efforts to support rapid PCR in Rwanda and across Africa. Caregivers should be encouraged to monitor HIV-exposed children from birth ensuring prompt diagnosis and early initiation to ARVs for children infected with HIV. PMTCT programs should be strengthened to achieve the minimum transmission of HIV. These efforts implemented in a comprehensive system of care focused on the family can significantly reduce pediatric deaths due to HIV.

6.6. Follow up of HIV infected children and exposed children overlooked in the follow up in Rwanda in 2009: Challenges and lessons learnt at the level of health facilities

Dr Aimable M, TRAC Plus

Today, there are 225 ARV sites and 365 PMTCT operational sites in Rwanda. The follow-up of children is not probably perfect and some gaps were found in HIV services. Only 6187 children are on ARVs over a total of 72,535 people on ARVs (TRAC net, August 2009). Results from the monitoring the trace activity of HIV-infected children overlooked jointly done by TRAC*Plus*, UNICEF and Clinton Foundation in 2007 for 110 health centres in RWANDA found 4087 children overlooked and 632 eligible for ARVs but not treated.

Thus, 326 health centres were visited from March to April 2009 and all the patients failing to services were identified through the files, records and database. We then gave all the health centres lists of the overlooked of by requiring health facilities to organize visits for the overlooked at their homes. A second visit, 3 months after the first, was held to see the state of the huge number of the overlooked. The activity was done from March to September 2009.

It was found in sites especially the delay in the implementation of national guidelines, non-use of data in health facilities to identify gaps and improve quality in their services. Many infected children are lacking in some services even those who regularly come to the facility. We also found a low accessibility of HIV services due to low national coverage of HIV services. Still, some sites do not offer the PMTCT minimum service package and refer children at risk.

The study recommends that the TRAC*Plus* should develop standardized tools on biological and clinical monitoring (patient's file, records, software ...), continued training and mentoring at the district level and decentralization of the monitoring of the overlooked at HF to be conducted on a regular basis.

For MoH, it is recommended to ensure ongoing supervision and mentorship at the health centres. Also, it will be necessary to build capacity and increase the number of staff at district level.

As for partners, they are requested to help HF organize home visits, increase the number of staff dedicated to HIV services and to ensure that the national protocol is being implemented in all health centres.

Regarding various HF, they are required to use data at site level to identify deficiencies early and find solutions (the needs of patients in ARVs, monitoring the number of CD4). They are also expected to improve monitoring pre and under ARVs and maintain regular and planned home visits for better patient monitoring.

Discussion and interaction

1. Regarding adherence, it was said that children and mothers understand well because the mothers are more empowered. For teenagers who have no parents, there is need for intervention of psychologists, counselors and active listening. Regarding these children's sexual behaviour, it was not studied but teenagers reported having not yet experienced sex. Still, CHUK uses the strategy to meet with tutors of children and they often get results;
2. Concerning mentorship, it was said that some partners have begun to use it by mentoring service providers first. However, there is still no harmonization. At the decentralized level, TRAC*Plus* is preparing tools. It was also stated that, at community level, we have patient representatives who participate in decision making;
3. Regarding early initiation of ARVs, it was explained that the program continues and that, in terms of hygiene, there is no problem because there is a team to help mothers prepare feeds. He pointed out that, up to date, there have been no cases of illness due to unhygienic food.

3. CLOSING CEREMONIES

3.1. Recommendations from the conference

Alfred KAREKEZI, MIGEPROF

Cross generational sex

1. To ensure wide involvement of stakeholders, including local authorities, in protecting the rights of children and young people against the phenomenon of 'sugar mammy' and 'sugar daddy';
2. To strengthen anti-AIDS clubs in schools and support the integration of dialogue about sex in reproductive health in the school environment;
3. To implement strategies to establish communication in order to address some cultural barriers to the promotion of parent-child communication on sexuality and reproductive health.

Prevention of HIV among youth and teenagers

1. To develop a framework and guidelines for HIV prevention among teenagers and young people including male circumcision;
2. To strengthen capacities of youth structures at the national and decentralized level for the coordination of interventions targeting HIV prevention among teenagers and the youth;
3. To strengthen youth-friendly centres in all districts with emphasis on VCT services to implement a minimum package of services;
4. To consolidate CCC strategies tailored to specific groups of young people including young people outside schools and those with disabilities;
5. To build capacity and knowledge among parents to communicate with children about HIV, reproductive health and carry out monitoring and evaluation of this activity;
6. To strengthen the monitoring-evaluation in order to report on activities of young people at all levels;
7. To organize friendly sensitization of the youth and mobilization at the village level (umudugudu).

Protection of OVC

1. To develop guidance and provide psychosocial support for the global implementation of all stakeholders;
2. To consolidate social welfare committees through training and financial support;
3. The social protection programs should be intensified to address the needs of OVC;
4. Best practices of different stakeholders should be documented and disseminated;
5. A mapping of all stakeholders should be conducted to identify all interventions in Rwanda.

Symposium on universal access

1. To strengthen HIV prevention among discordant cohabiting couples;
2. To develop a policy and guidelines on re-screening in the PMTCT service even during maternal breastfeeding (for safe pregnant mothers with HIV positive partners);
3. To strengthen HIV prevention in high risk groups including sex workers;
4. To consolidate the integration of family planning into HIV services;
5. To improve early diagnosis of HIV in children, including transport of samples and results in addition to the link with vaccination;
6. To increase advice to families who do not get their children tested;
7. To ensure the implementation of task transfer policy;
8. To review the current guidelines on ARVs in PMTCT including ARV prophylaxis during breastfeeding;
9. To provide quality services through consolidation of the monitoring-evaluation system that includes the integration of the guide of auditing data and the supervision guide.

PMTCT

1. To integrate a social protection mechanism (e.g. AGRS) to mitigate the impact of HIV/AIDS and ARV treatment on mothers and children at risk;
2. To integrate PMTCT into MCH in all health centres and implement a pilot HIV integration in the vaccination program;
3. To revise guidelines for integrating early PMTCT strategies to prevent the population of HIV transmission after birth through maternal breastfeeding;
4. To develop and implement strategies to increase acceptance and adherence to quality for mothers and babies in the context of decentralization (transfer of tasks, psychosocial support through support groups of PVVIH);
5. To reinforce the message of child nutrition for placing exclusive breastfeeding in the centre of the child survival strategy.

Pediatric Care and Treatment

1. To review policies, guidelines and protocols to include the care of teenagers;
2. To integrate the aspect ‘teenagers’ into different levels of training (services, pre-service training curricula);
3. To review PMTCT Guide based on evidence in the field of child nutrition;
4. To improve the quality of monitoring of children in programs (standardizing tools for M & E, strengthening of mentorship)
5. To engage the community in the management, care and monitoring of children exposed and infected with HIV.

3.2. Recommendations from the children's session

General recommendations

The district authorities should assist children in transmitting information from the conference to HIV affected children.

Specific recommendations

1. HIV Prevention

Identified problems	Recommendations	Responsible
Young people do not have adequate knowledge about HIV/AIDS	• To increase training on HIV/AIDS through radio and other newspapers, songs, drama and especially in comic strips; • To create anti-AIDS clubs in all schools, both primary and secondary and in all sectors; • To strengthen the capacity of anti-AIDS clubs through training and distribution of materials that facilitate young people to convey their messages; • To help children's associations in planning in order to raise the awareness of children and parents about the prevention of HIV/AIDS; • To raise awareness through testimony during communal work (Umuganda) and other meetings held in umudugudu.	CNLS, CDLS/ Children and stakeholders
The number of circumcised children is still very low	• To strengthen health centres to enable them to circumcise children from neighbouring areas; • To circumcise freely or integrate circumcision into services supported by Health Insurance; • To sensitize parents on circumcision of their children at birth; • To develop specific circumcision programs of students who were not circumcised during the holidays.	MOH
Parents do not talk with their children about	• To prepare booklets that contain reliable information that can help parents educate	CNLS/ MIGEPROF

reproductive health and HIV/AIDS	their children about reproductive health and HIV/AIDS; • Children should dare ask their parents questions about the reproductive health and HIV/AIDS; • To establish a family day where parents have the opportunity to interact with their children for at least 2 hours and authorities must ensure that this dialogue took place; • Parents should educate their children on the values of humanism;	Children's groups
Girls are more exposed to HIV infection than boys of the same age	• Girls should be educated to be satisfied with what they receive from parents or guardians and avoid peer pressure that leads them to risky behaviour; • Mentorship must be strengthened so that each child has a mentor; • Girls should be able to say 'no' and stand firm on their decisions; • To develop strategies and define sanctions against Sugar Mammy and Sugar Daddy including denouncing them and blaming them publicly; • To create groups for teaching culture and establish prizes for girls who behave well.	MINEDUC MINISTRY OF YOUTH MIGEPROF MININTER MINIJUST
Counseling and voluntary testing in VCTs is still low among the youth	• To increase VCT youth centres; • To train service providers and sensitize them on offering quality services and showing humanism in the care of patients.	MOH
The youth do not have sufficient information and knowledge on the correct use of condoms	• Parents should make much more effort to teach their children values of the Rwandan culture such as abstinence and patience before sensitizing them on the use of condoms.	MIGEPROF

1. Protection, care and pediatric care

Children with problems do not have people they can confide in at school	• There should be counselors in schools to assist children who have problems at school; • Capacity building for teachers and principals of schools in HIV/AIDS to enable them to help students in schools.	MOH MINEDUC
Support destined for the OVC is not given to	• Children representing others want to be	MIGEPROF, MINALOC

real beneficiaries	involved in identifying OVC and in monitoring the assistance granted to them; • To establish a support program for small projects of children to enable them to buy necessary basic material; • To deliver on time equipment and other assistance to eligible children; • To establish mechanisms to coordinate support offered to OVC by various stakeholders in order to avoid that there is duplication, while some children in need have not received any help; • Rapid intensification of the 2020 Vision program in all sectors.	CNLS CNLS/MINALOC MIGEPROF

Children carefully participating in a plenary session (Photo CNLS)

PMTCT

Identified problems	Recommendations	Responsible
HIV positive women keep producing children	• To integrate monitoring services for children exposed to HIV into the immunization services; • To establish advisors/mentors at the level of villages (imidugudu) who follow up parents' adherence to ARV; • To raise awareness of parents living with HIV to adhere to the family planning program; • To increase the number of sites offering PMTCT services taking into account their accessibility by the population; • To sensitize husbands to accompany their wives for VCT and PMTCT services.	MOH/ CNLS

2. **Care and treatment of HIV-infected children**

- We congratulate the MOH for having set up the early screening program for infants (before 18 months), which increases their chances because they are followed closely in time;
- We appreciate that there are now in Rwanda ARVs specific to children living with HIV because this is an implementation of one of the recommendations we made in previous conferences;
- We call on MOH to intensify early screening of the newborns (EID) to enable them to have good life and be quickly followed;
- We request both parents to feel concerned about the life they are creating and to respect the advice and commitments taken with their advisor/mentor and doctor.

Commitments of Children

- As children, we are committed in the context of changing attitudes of our parents, to request the floor/participation in their different meetings (churches, cooperatives and community works) and to talk with them by raising their awareness on the protection of HIV-infected children through the provision of good nutrition and medical treatment in time;
- Regarding the invitation for parents to dialogue on reproductive health, as children, we pledge to change the attitude of our parents via conviviality where we will play theaters and other games prepared in children's meetings organized at the sector level;

With a view to protecting ourselves and our colleagues, as "intore", we are committed to respect Rwandan values, namely self-respect, mutual assistance and solidarity in fighting against stigma both at school and at home because it affects lives of HIV-infected children.

3.3. Perspectives

These perspectives were read by Dr. Anita ASIIMWE, the Executive Secretary of CNLS.

1. Drawing up a plan of action based on conference recommendations at the end of January 2010 by the "steering committee". For each area, bearing in mind MDGs indicators ;
2. Financial commitments made by Government and partners;
3. Implementation in 2010 by Government and partners;
4. Quarterly monitoring by the "steering committee" in 2010 ;

Preparation of the conference of 2010:

1. Proposal for the overall theme of the conference to be made from 18 November 2009 to 5 February 2010 and sent out to info@cnls.gov.rw;
2. Proposed dates: 17-19 November 2010 ;
3. Organization of the conference to start in June 2010 ;
4. Organisation of 2 symposiums for specific questions. Suggestions to be forwarded to info@cnls.gov.rw ;

Some themes put forward for symposium scheduled in 2010:

1. Framework, guidelines and package for HIB prevention in youth and adolescents ;
2. Implementation of social protection mechanisms;
3. Implementation of PIT and counseling ;
4. Implementation of guidelines proposed for ARV during breastfeeding;
5. Implementation of task transfer policy.

3.4. Prize giving ceremony

The prize giving ceremony is one of the innovations of the 5th National Paediatric Conference on children infected and affected by HIV& AIDS. It is intended to reward excellence and innovation in responding to children's challenges and HIV. More importantly, it will emulate the work of young researchers by catalyzing knowledge sharing and documentation of the excellent work being done in Rwanda.

Nine prizes were distributed in 3 categories of competition: innovation (4 prizes), young researchers (4 prizes) and district excellent intervention (1 prize).

For selection process, a prize selection committee represented the 4 prizes, supervised the selection process coordinated by the Chairperson and co-chairperson of the conference. Award winners were chosen following a strict, transparent and documented process.

Innovation prize for 2009

This prize is awarded to an author whose work introduces an innovative approach or tool to address a major challenge in the response to HIV pandemic and children in the context of Rwanda.

P1- Prevention in adolescents and youth

Title of abstract: tool to evaluate the effectiveness of youth peer-education training.

RUCYAHANA Emmanuel, *PSI/Rwanda*

P2- Prevention of mother-to-child HIV transmission

Title of abstract: Strengthening the monitoring of HIV exposed children through vaccination service.

Dr Placidie MUGWANEZA, *TRAC Plus*

P3- Care and paediatric treatment for HIV infected children

Title of abstract: Early initiation to ARV leads to excellent survival for HIV infected babies in Rwanda

Dr. CYAMATARE RWABUKWISI Felix, *Partners In Health/RWINKWAVU district Hospital*

P4- Protection of OVC

Title of abstract: Mainstreaming HIV prevention and care with psychosocial treatment of trauma in vulnerable children in Rwanda.

Chaste UWIHOREYE, *UYISENGA N'MANZI*

Prize for young researcher, 2009

This prize rewards scientific excellence in the work done by young Rwandan authors under 30 years of age.

P1- HIV prevention in adolescents and youth

Title of abstract: Response to HIV/AIDS in schools supported by education managers, teachers and students

Jean Claude NSHIMIYIMANA, VSO

P2- PMTCT

Title of abstract: Role, impact and effectiveness of DBS PCR lab protocol in early diagnosis of children in national laboratory in sites with limited resources in Nyamasheke District.

Ali KWIZERA, University Of Maryland School Of Medicine

P3- Paediatric care and treatment for HIV infected children

Title of abstract: Trend in paediatric ARV treatment in Rwanda

Ladislas BIZIMANA**,** TRAC Plus

P4- Protection of OVC

Title of abstract: Children support groups: offer of a quiet and supportive space in Kigali

MULINDA Bertin, WE ACTX

District excellent intervention in 2009

This prize rewards scientific excellence in resolving an important problem relating to children and HIV at district level.

Title of abstract: Role, impact and effectiveness of DBS PCR lab protocol in early diagnosis of children in national laboratory in sites with limited resources in Nyamasheke District.

Ali KWIZERA, **UNIVERSITY OF MARYLAND SCHOOL OF MEDECINE**

3.5. Remarks by the UN Representative

On behalf of the United Nations Family, Dr. Jane Muita said she was happy to see the 5th National Paediatric Conference taking place at the same time as the 5th anniversary of Rwanda.

Going back to the situation of Rwanda in the area of HIV and children, she reminded participants of the innovations already made, namely the first National Paediatric Conference on Children Infected and Affected by HIV/AIDS, the prizes awarded to best researchers, introduction of paediatric treatment of HIV whereas no other country in the world has ever done so, definition of social protection mechanism which will make it possible to support families and OVC through Vision 2020 Umurenge and implementation by Rwanda of the Convention on the Rights of the Child like getting them involved in activities concerning them.

However, she recalled that despite many achievements, there is still a long way to go. Indeed, children still die of lack of treatment; nutrition for HIV exposed children is still a big concern as long as HIV transmission through breastfeeding still exists.
There is therefore need to improve performances and put in place structures necessary to achieve effective HIV prevention.

Before closing her remarks, Dr. Muita thanks CNLS and promised that the United Nations are determined to continue helping Rwanda to go ahead and achieve MDG-6 objective.

3.6. Official closing speech

The Minister of Education, Dr. Charles MULIGANDE,
Officially closing the 5th Annual National Paediatric Conference on Children infected and affected by HIV/AIDS

In his closing remarks, Dr. Charles MULIGANDE, Minister of Education first said he was greatly pleased to be with participants at the closing ceremony of the 5th Annual National Paediatric Conference on Children infected and affected by HIV/AIDS.

He declared that the conference had been of great value as of the time it brought together various categories of stakeholders in the area of HIV/AIDS. He further indicated that the conference gave participants the opportunity to express their satisfaction for the work done not only for the substance of discussions held, but also and especially for the commitments which every participant resolved to translate into concrete action.

Going back to the progress made by Rwanda in the area of HIV care and prevention in children, he stressed the big efforts made to achieve "MDG-6".

He commended the political will and commitment which legalized the ambitions of improving the state of children.

He also said there was no doubt that the new series of measures and recommendations formulated will be implemented through the consultative structure of which results are obvious.

He used this opportunity to thank all prize-winning persons and encouraged all stakeholders, researchers and authors to work hard in order to be listed among the happy few who will be awarded prizes next year. He also thanked conference organizers for the excellent work done, presenters and all participants who came from all the districts of the country and particularly those who represent the international arena for having contributed to making this event a great success. Lastly, he expressed gratitude to partners who provided financial and technical support to ensure the success of the conference. On that note, he declared officially closed the 5th Annual National Paediatric Conference on Children Infected and Affected HIV/AIDS.

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APPENDICES

Annex 1: Program

	November 16, 2009
	Symposium
Theme:	Cross-generational sex and challenges for HIV prevention among youth and adolescents in Rwanda
Moderator:	*Odette Uwamariya-Lycée Notre Dame de Cîteaux*
Rapporteurs:	*Jean Pierre Ayingoma-CNLS*
Panelists:	*Gasaza Faustin-KHI, Munana Brenda-FAWE Girls Mukanyandwi Clarise-AGR*
5.00-5.30	Participant registration and entertainment by Rwandan Musicians
5.30-5.40	Introduction *CNLS*
5.40-5.55	Cross-generational sex in Rwanda: Evidence, response and challenges MINIYOUTH
6.00-6.30	Drama on cross-generational sex UNR-University centre for arts
6.30-7.30	Open Discussion and Q&A Panelist
6.30-7.30	Children and Youth Presentations through music dance and drama *UNR-University centre for arts*
	November 17, 2009
Session 2	Prevention of HIV amongst Adolescents and Youth
Theme:	Improving Access to HIV Prevention Services to Young People in Rwanda
Moderator:	*Cheick Fall-UNFPA*
Rapporteurs:	*Jean Marie Niyitegeka-MINIYOUTH Gatete Désiré-Rwanda National Youth Council*
7.30-8.30	Participant registration
8.30-8.45	MDG-6 Status for Children and HIV in Rwanda *Dr. Anita Asiimwe-CNLS Executive Secretary*
8.45-9.15	Discussion and Interaction
9.15-9.30	International Key note address -Presentation on Global situation *Dr. Fatma Mrisho-Executive Secretary National AIDS Control Commission,Tanzania*
9.30-9.45	National Key note address -Presentation on Rwanda situation *Mukunzi Batete Redempter-MINIYOUTH*

9.45-10.15	Discussion and Interaction
10.15-10.30	Coffee break
10.30-11.15	Oral abstract presentation An evaluation tool to measure effectiveness of youth peer education training-Rucyahana Emmanuel, PSI Design of the SINIGURISHA campaign against Cross-Generational Sex Jean Pierre Ayingoma-CNLS Predictors of HIV status among youth aged 15-24 accessing voluntary counseling and testing (VCT) services at "Dushishoze" youth centres in Rwanda- Mukamusoni Concessa-TRAC Plus
11.15-11.45	Discussion and Interaction
11.45-12.00	Summary of key recommendations and way forward
12.00-01-00	Lunch

November 17, 2009

Session 3	Protection and Support of Orphans and Vulnerable Children
Theme:	Strengthening Family Capacities to Protect, Care and Support OVCs
Moderator:	*Munyura Pierre-CHF*
Rapporteurs:	*Uwineza Louise-World Relief Ruzibiza Joie Grace-MIGEPROF*
1.00-1.15	International Key note address The potential of cash transfer to strengthen families affected by HIV and AIDS Chris Desmond-Harvard University
1.15-1.30	National Key note address Presentation on Rwanda situation Mr.Gatsinzi Justin–MINALOC
1.30-2.00	Discussion and Interaction
2.00-2.45	Oral abstract presentation Integrating HIV Prevention and Care with Treatment of Psychological Trauma in Vulnerable Rwandan Youth: A Community-based Intervention-Chaste Uwihoreye , UYISENGA N' IMANZI A Family-Centered Approach to Mental Health Promotion in Rwandan HIV/AIDS-Affected Youth- Sara Stulac-PIH Level and correlates of depression in youth heads of households (YHH) in mentorship program; Bugesera District, Rwanda-Mukabutera A-World Vision
2.45-3.15	Discussion and Interaction
3.15-3.30	Coffee Break
3.30-3.40	Summary of key recommendations and way forward

5.00-7.00	Evening Symposium on Session 4

November 17, 2009

Session 4	Symposium on Universal Access to HIV Prevention, Care and Treatment Services in the Health Sector
Theme:	Achievements and Challenges to achieve Universal Access to HIV prevention, Care and Treatment Services in the Health Sector
Moderator:	*Dr. Anita Asiimwe-CNLS Executive Secretary*
Panelists:	*Dr. Agnes Binagwaho-Permanent Secretary MOH* *Dr. Abdoulie Jack-WHO Representative* *Dr. Joseph Foumbi-UNICEF Representative* *Dr. Pratima Raghunathan-Director of CDC Rwanda* *Dr. Amadou Mbaye-UNAIDS Country Coordinator*
Rapporteurs:	*Elizabetha Pegurri-UNAIDS* *Dr. Vincent Mutabazi-TRAC Plus*

5.00-5.30	Participant registration and Cocktail
5.30-5.35	Introduction and welcome *Dr. Anita Asiimwe-CNLS Executive Secretary*
5.35-5.55	The 2009 report on Universal Access to HIV prevention and Care and Treatment services in health sector – Global perspective *Dr. Sobela Francois-WHO*
5.55-6.10	Rwanda achievements and challenges towards Universal Access to HIV prevention and Care and Treatment services in the health sector *Dr. Jules Mugabo-TRAC Plus*
6.10-6.45	Open discussion Q&A, *Panelist*
6.45-7.00	Recommendations and The Way Forward *Moderator*

November 18, 2009

Session 6	Paediatric Care and Treatment of Children Infected by HIV
Theme:	Early diagnosis of HIV for early treatment of children
Moderator:	*Dr. Martha Mukaminega-EGPAF*
Rapporteurs:	*Dr. Mpundu Ribakare-TRAC Plus Freddy Munyaburanga-Clinton Foundation*

1.00-1.15	International Keynote Address Presentation on Global situation *Prof. Douglas Watson-University of Maryland, School of Medicine*
1.15-1.30	National Keynote Address Situation of Paediatric HIV Care and Challenges to Adolescent Care in Rwanda *Dr. Agnes Binagwaho-Permanent Secretary MOH and Dr. Sabin Nsanzimana-TRAC Plus*
1.30-2.00	Discussion and interaction
2.00-2.45	Oral abstract presentation Adolescent children adherence to HIV Care and Treatment: The Experience of the Kigali and Butare University Teaching Hospitals (CHUK and CHUB) in Rwanda (2006 – 2009)-Prof. Narcisse Muganga-CHUK Early ART Initiation Leads to Excellent Survival in HIV-Infected Infants in Rwanda- *Rwabukwisi Cyamatare-Rwinkwavu Hospital* HIV infected and exposed children lost to follow up in Rwanda, 2009-Aimable Mbituyumuremyi-TRACPlus
2.45-3.15	Discussion and Interaction
3.15-3.30	Coffee Break
3.30-4.00	Summary of key recommendations and way forward

November 18, 2009

Closing Ceremony

Chair:	*Dr. Anita Asiimwe-CNLS Executive Secretary*
MC:	*Antoine Semukanya-CNLS Deputy Executive Secretary*
Rapporteurs:	*Amina Rwakunda-CNLS Bernadine Mukakizima-UNICEF*

5.00-5.10	Presentation of conference recommendations sessions 1-6 *Alfred Karekezi-MIGEPROF*
5.10-5.20	Presentation of conference recommendation from children and youth parallel session. Youth Presenter
5.20-5.25	The Way forward Dr. Anita Asiimwe-Executive Secretary-CNLS
5.25-6.10	Awards Ceremony Antoine Semukanya-Deputy Executive Secretary-CNLS

6.10-6.20	Closing Remarks UN Resident Co-ordinator
6.20-6.30	Closing Address-Guest of Honour Hon. Richard Sezibera-Minister of Health
6.30-7.00	Entertainment and Cocktail

No	NAME	INSTITUTION	POST
1	A - D - JACK	WHO	Representative
2	AFRIKA Fulgence	Access Project	Project Coordinator
3	Aimable RUMONGI	SYMPOSIA	Interpreter
4	Alexis BAMAGE	GRAND LACS HEBDO	journalist
5	ALFRED G.	SMART SOUND VIDEO	Sound technician
6	Alimas HAKIZIMANA	CHF/RWANDA	Progr.
7	AMADU MOCTAL MBAYE	UNAIDS	ROP
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13	BAHATI Innocent	ABASIRWA	Executive Secretary
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17	BAZAMBANZA Pascal	BURERA DISTRICT	AT/CDLS
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23	BIZIMANA Roland	CDLS NYAGATARE	A.T
24	BYAMUNGU Tharcisse	CDLS	A.T/KIREHE
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27	DAVID NEZYIMANA	CNLS	Fellow
28	Debrito Abcde bitv	Africa Humanitarian	Country representative
29	DESMOND Chris	HSPH	
30	Dieudonné NZEYIMANA	USAID/Land O' Lakes	M&E specialist
31	Dr Aloys HAKIZIMANA	UNICEF	CND Manager
32	Dr Andre MBAYIHA	AHF	Clinical Director
33	Dr Dorethy Mboni-Ngenda	UNICEF	HIV/Advisor
34	DR FATIMA MRISHO	UNFPA	Consultant
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37	Dr Josette MAZIMPAKA	CHUK	Medical Doctor
38	Dr KAMBAZE WAINDA Paul	CHUK	Medical Doctor
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50	Dr.Mfinzi Jean	PMU/GF/CNLS	Care and treatment officer
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101	KANTARAMA mectilde	UNICEF	Participant
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117	Londy Isogwe	UNICEF	HIV commodities supply chain analyst

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125	Mbaraga Pacifique	VNU AT CDLS Ruhango	journalist
126	MBONANKIRA Romuald	ADRA RWANDA	
127	MOHAMED	SMART SOUND VIDEO	HEALTH COORDINATOR
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130	MUDENGE Theophile	Africare	Social P.
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132	MUGISHA Ben	Artist	interpreter
133	MUGISHA Ben	ARTIST	Artist
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144	MUHORAKEYE Assoumpta	CONSELLOR	Director
145	MUHOZA Grace	Guide	
146	MUKABALISA Simbi Dative	District KARONGI	Facilitator
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150	MUKAKAMANA Amielle clemence	DISTRICT DE RUTSORO	Commissioner
151	MUKAKIBBI Perpetue	IMBUTO FONDATION	CNF
152	MUKAKIBIBI PERUTH	Imbuto Foundation	member
153	MUKAMANA Esperance	USAID	member
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157	MUKAMBANDA Mariam	Coop.Wibabara	Facilitator
158	MUKAMISHA Triphose	NGORORERO District	V/P
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160	MUKAMUHIRWA Euphrasie	G.S ste RITA	Program officer
161	MUKAMUTEGA Flavia	UNICEF	Teacher
162	MUKANGARAMBE Patricie	Intrahealth/HCSP	
163	MUKANTAGWABIRA M.claire	ATRACO	Clinical services officer
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165	MUKARWEGO M. Louise	HUYE DISTRICT	T-Counselor
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168	MUKESHIMANA Pascasie	CHUB	P C Officer
169	MULINDA SHAMBO Bertin	WE ACTX RWANDA	Sociologist
170	MUNGARULIRE Janvier	CNLS	Children and HIV Officer
171	MUNGWATRAKARAMA Déo	CJNR	
172	MUNYAMPUNDU	Artist	Facilitator
173	MURANNGIRA Théogene	FIDESCO-RWANDA	Journalist
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181	MUSABYEMALIYA Alphonsine	DISTRICT DE KAMONYI	T.O.
182	MUSANABAGANWA Eugenie	ICAP	AT/CDLS
183	MUTABAZI Alexis	SWAA Rwanda	NO
184	MUTAGOMA F. DAMAS	Children	OVC Officer
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186	MUTEGWARABA A. M.	BASICS RWANDA	NPO/HIV
187	MUTETELI Donatha	COOP.DUFATANYE	CCM Coordinator.
188	MUTONI Jane	CHF-RWANDA	Chairperson
189	MUTUNZI Antoine	District de Ruhango	OVC Officer
190	MUTUYIMANA Justin	CDLS	AT/CDLS
191	MUVONA Eric	City Radio	UN/ Musanze
192	MUZUNGU Kumwani	CHUK/Pédit.	Journalist
193	MWANANAWE Aimable	Rwanda NGOF	Medical Doctor
194	MWIZERWA Jeand de Dieu	CDLS	Chairperson
195	NDAGIJIMANA GATUKU Aloys	MIGEPROF	AT/CDLS

196	NDAGIJIMMANA Lyhotely	ARBEF	EX. SECRETARY GF
197	NDAGJIMANA Alphonse	DISTRICT DE MUHANGA	Chairperson
198	NDAHIMANA J. D'Amour	TRAC PLUS	A.T
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